Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

AMENDED MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: HARRIS METHODIST OF FORT WORTH 3255 W PIONEER PKWY ARLINGTON, TX 76013	MFDR Tracking #: M4-09-7203-01
Respondent Name and Box #: TRAVELERS PROPERTY CASUALTY CO REP BOX # 05	

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary

"We have found in this audit they have not paid what we determine is the correct allowable per the Medicare fee schedule…."

Principle Documentation:

1. DWC 60 package
2. Hospital Bills
3. EOBs
4. Medical Reports
5. Total Amount Sought $1,338.19

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "…Regarding CPT code 85025, the Carrier reimbursed the Provider $13.57, while the Provider contends the proper MAR is $21.72. The Carrier reviewed the billing and reimbursed the Provider pursuant to the DWC Medical Fee Guideline for Professional Services for this CPT code, pursuant to the Medicare edits for the CPT codes billed. CPT code 85025 is tagged with APC Status A. As the Carrier reimbursed these services in accordance with the DWC Medical Fee Schedule, the Provider has been properly reimbursed under the DWC fee guidelines and applicable Medicare edits. With regards to the remaining CPT codes, the Carrier denied these codes as included in the primary emergency admission reimbursement. The Carrier contends the Provider is not entitled to additional reimbursement"

Principle Documentation:

1. DWC 60 package

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Services in Dispute	Calculation	Amount in Dispute	Amount Due
07/14/2008	85025, 76376 5 Units, 94760, 99284-25	$0(APC 94760, 76376) + $13.57 (Fee Schedule 99284-25, 85025)+$0 (Outlier Amount) = $0	$1,338.19	$0
			Total Due:	$0

PART V: AMENDED REVIEW, METHODOLOGY AND EXPLANATION

This **Amended** Findings and Decision supersedes all previous Decisions rendered in this medical payment dispute involving the above Requestor and Respondent. The Medical Fee Dispute Resolution decision of July 28, 2009 was issued did not specifically address the services in dispute.

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule §134.403, titled ***Hospital Facility Fee Guideline – Outpatient,*** effective for medical services provided in an acute care hospital on or after March 1, 2008, set out the reimbursement guidelines for Hospital outpatient services.

This dispute was filed in the form and manner as prescribed by 28 TAC §133.307 and is eligible for Medical Dispute Resolution under 28 TAC §133.305 (a) (4).

1. The services listed in Part IV of this decision were denied or reduced by the Respondent with the following reason codes:
   - "TXPF-W1 Workers Compensation state fee schedule adjustment. This service is re-priced according to the TX physician fee schedule."
   - "INCL-W1 Workers Compensation state fee schedule adjustment. Packaged services are included in the APC rate."
   - "TXPK-97 Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Payment included in APC rate per TX hospital Medicare met hodology per rule 134.403 (D)."
   - "Z10F-W4 No additional reimbursement allowed after review of appeal/reconsideration. After carefully reviewing the resubmitted invoice. Additional reimbursement is not justified."
   - "T182-97 Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Payment included n APC rate per TX hospital Medicare methodology per rule 134.403 (D)."
2. Rule 134.403 (e) states in pertinent part, "Regardless of billed amount, reimbursement shall be:

   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code 413.011; or

   (2) if no contracted fee schedule exists that complies with Labor Code 413.011, the maximum allowable reimbursement (MAR) amount under subsection (f), including any applicable outlier payment amounts and reimbursement for implantables;"
3. Pursuant to Rule §134.403(f), "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the *Federal Register.* The following minimal modifications shall be applied.
   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
      (A) 200 percent; unless
      (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent.
4. Under the Medicare Outpatient Prospective Payment System (OPPS), all services paid under OPPS are classified into groups called Ambulatory Payment Classifications or APCs. Services in each APC are similar clinically and in terms of the resources they require. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC for an encounter. Within each APC, payment for ancillary and supportive items and services is packaged into payment for the primary independent service. Separate payments are not made for a packaged service, which is considered an integral part of another service that is paid under OPPS. An OPPS payment status indicator is assigned to every HCPCS code. Status codes are proposed and finalized by Medicare periodically. The status indicator for each HCPCS codes is shown in OPPS Addendum B which is publicly available through the Centers for Medicare and Medicaid services. A full list of status indicators and their definitions is published in Addendum D1 of the OPPS proposed and final rules each year which is also publicly available through the Centers for Medicare and Medicaid services
5. In reference to disputed codes 76376 and 94760, the payment status indicator for both is N. N is defined as "Paid under OPPS; payment is packaged into payment for other services, including outliers. Therefore, there is no separate APC payment." It is for this reason that payment can not be recommended for these disputed services.

6. In reference to disputed code 99284-25, the payment status indicator is Q. Q is defined as "Paid under OPPS; Addendum B displays APC assignments when services are separately payable. (1) Separate APC payment based on OPPS criteria. (2) If criteria are not met, payment is packaged into payment for other services, including outliers. Therefore there is no APC payment." According to Medicare OPPS, Medicare Claims Processing Manual (Chapter 4, Part B Hospital), section 160 titled Clinic and Emergency Visits, each hospital's internal guidelines should follow the intent of the CPT code descriptors. CPT 99284 – Emergency department visit for a new or established patient used to report evaluation and management services provided in the emergency department which requires these three key components: an expanded problem focused history; an expanded problem focused examination and a medical decision making of moderate complexity. The description of the 25 modifier is as follows: Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service. Documentation does not support 99284-25 was a separately identifiable evaluation and management service. It is for this reason, payment can not be recommended for this disputed service.
7. In reference to disputed code 85025, the Division offers the following: Pursuant to Rule §134.403(h) medical services provided in an outpatient acute care hospital, but not addressed in the Medicare payment policies as outlined in subsections (f)(1) or (f)(2). When Medicare reimburses using fee schedules other than OPPS, reimbursement shall be made using the applicable Division Fee Guideline in effect for that service on the date the service was provided. 28 TAC Section 134.203(e)(1)(2) states the MAR for pathology and laboratory services not addressed in subsection (c)(1) of this section or in other Division rules shall be determined as follows: 125 percent of the fee listed for the code in the Medicare Clinical Fee Schedule for the technical component of the service; and, 45 percent of the Division established MAR for the code derived in paragraph (1) of this subsection for the professional component of the service. The Carrier reimbursed the Provider 125% of the Medicare Clinical Fee Schedule which is $10.86 for a total of $13.57. It is for this reason that no additional reimbursement is recommended for this disputed service.

Based upon the documentation submitted by the parties and in accordance with Texas Labor Code Sec. 413.031 (c), the Division concludes that the requestor is not due additional payment. As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. 413.011(a-d), 413.031 and 413.0311
28 TAC Rule §134.403
28 TAC Rule §133.307
28 TAC Rule §133.305
28 TAC Rule §133.203

PART VII: DIVISION DECISION

In accordance with the provisions of Texas Labor Code, Sec. §413.031, the Division has determined that the Requestor is entitled to $0.00 reimbursement.

Authorized Signature	Medical Fee Dispute Resolution Manager	Date

PART VIII: : YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.